



INTERNET MEDICAL GROUP, P.C.

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Nutley, NJ 07110  
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Dr. Edward Vecchione   
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### Medical Record Release

Patient Name: _____	Date of Birth: _____
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*I hereby authorize and request Internet Medical Group:*

<input type="checkbox"/> <i>To release medical records to:</i> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	<input type="checkbox"/> <i>Obtain medical records from:</i> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____  Please <b>FAX</b> all records to <b>973-667-6642</b> .
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**Check all that applies:**

- |  |  |
|--|--|
| <input type="checkbox"/> Chart Notes             | <input type="checkbox"/> Immunizations   |
| <input type="checkbox"/> Lab Results             | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> X-rays/Diagnostic Tests | <input type="checkbox"/> All Records     |
| <input type="checkbox"/> Other: _____            |  |

I understand that I may revoke this authorization in writing at any time to IMG, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will not expire. My signature below authorizes release of information unless I have marked NO and initialed it.

Yes  No Initials \_\_\_\_\_

Signature/Legal Responsible Party: \_\_\_\_\_

Relationship to Patient if not Patient: \_\_\_\_\_

Date: \_\_\_\_\_